DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 6/26/14

PRINTED: 05/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445143	A. BUILDING _____ B. WING _____	05/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT ROCKWOOD, THE	5680 ROANE STATE HWY ROCKWOOD, TN 37854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification and complaint survey (#33534, #33782) conducted May 5-May 12, 2014, at The Bridge at Rockwood, no deficiencies were cited in relation to the complaint #33534, under 42 CFR Part 483.13, Requirements for Long Term Care.	F 000	The Bridge of Rockwood does believe and does not admit that any deficiencies existed, before, during, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	6/17/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan to address Pneumonia and a Urinary Tract Infection for one resident (#27) of thirty-five	F 279	F 279 1. A care plan review was completed on resident #27 and changes were made as needed. 2. All care plans of residents who have infections were reviewed and updated as needed. 3. Education will be provided by the DON to the MDS nurses. The SDC will provide education to the licensed nurses that will include updating the care plans for infections and antibiotic use. This education will be completed by 6/17/2014. Orders will be reviewed daily Monday through Friday in the clinical meeting by the DON, ADONs, and care plan nurse to ensure that the order and care plan interventions have been implemented and to ensure the care needs of the residents are met.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Main — TITLE: Administrator — (X6) DATE: 5-27-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 residents reviewed. The findings included: Resident #27 was admitted to the facility on March 11, 2014, with diagnoses including Renal Failure, Muscle Weakness, Atrial Fibrillation, Iron Deficiency Anemia, Hypothyroidism, Hyperlipidemia, Malignant Hypertension, and Esophageal Reflux. Medical record review revealed the resident was transferred to the hospital on April 1, 2014, and returned to the facility on April 9, 2014. Medical record review of the physician's readmission orders dated April 9, 2014, revealed the resident was to receive Cleocin (antibiotic) 150mg (milligrams) two orally every eight hours for treatment of Pneumonia. Medical record review of a positive urine culture, with sensitivity, collected on April 23, 2014, and received by the facility on April 25, 2014, revealed the causative organism for the infection was Klebsiella ozaenae. The report indicated a sensitivity to Levofloxacin (antibiotic). Medical record review of a physician's order dated April 25, 2014, revealed the resident was to receive Levaquin 500mg by mouth daily for seven days for treatment of the Urinary Tract Infection. Medical record review of the Interdisciplinary Care Plan dated March 24, 2014, revealed no documentation a care plan had been developed to address the resident's Pneumonia; and had not developed a plan of care to address the administration of antibiotics to treat the resident's	F 279	4. Findings of the above stated audits will be discussed in the QAPI meetings monthly for 3 months for recommendations and follow up as indicated. QAPI members consist of but are not limited to the Medical Director, Director of Nursing, Administrator, Assistant Director of Nursing, Social services Director, Dietary Director, Quality of Life Director.	6/17/14

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F 279	Continued From page 2 Urinary Tract Infection. Interview on May 6, 2014, at 3:35 p.m., with Registered Nurse #3, at the nursing station, confirmed a care plan had not been developed to address the Pneumonia or the administration of antibiotics to treat the resident's Urinary Tract Infection.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to revise the care plan for one resident (#136) of thirty-five residents reviewed.	F 280	F 280 1. Resident #136: care plan was reviewed and updated as needed. 2. All care plans of resident who have infections were reviewed and updated as needed. 3. Education will be provided by the DON to MDS nurses. The SDC will provide education to the licensed nurses that will include updating the care plans for infections and antibiotic use. This education will be completed by 6/17/2014. Orders will be reviewed daily Monday through Friday in the clinical meeting by the DON, ADONs, and care plan nurse to ensure the order and care plan interventions have been implemented and to ensure the care needs of the residents are met. 4. Findings of the above stated audits will be discussed in the QAPI meetings monthly for 3 months for recommendations and follow up as indicated.	6/17/14

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F 280	Continued From page 3	F 280		

The findings included:

Resident #136 was admitted to the facility on December 21, 2011, with diagnoses including Dementia with Behavioral Disturbances, Lack of Coordination, Muscle Weakness, Atrial Fibrillation, and Neuropathy.

Medical record review of the Quarterly Minimum Data Set (MDS) dated April 15, 2014, revealed "...Functional Status: Needs extensive assistance with toileting, and personal hygiene, totally dependent for bathing..."

Medical record review of the resident's care plan dated January 23, 2014, and updated April 23, 2014, revealed the identified problem of "...has a potential for complications associated with urinary incontinence and is at risk for: skin breakdown and UTI (Urinary Tract Infection)."

Medical record review of the physician's Telephone Orders dated April 26, 2014, revealed an order for a Urinalysis, Culture and Sensitivity "if indicated." Further review of the order revealed the indications/diagnosis for the laboratory studies were Dysuria (painful urination), Confusion, and Agitation. Medical record review of the results of the Urinalysis revealed a large amount of Leukocytes (white blood cells) and positive nitrite, indicating an infection.

Medical record review of the physician's Telephone Orders dated April 26, 2014, revealed the physician ordered the resident to receive Bactrim DS (an antibiotic, double strength) twice a day for the duration of ten days "for UTI."

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F 280	Continued From page 4 Further review of the resident's current care plan updated April 23, 2014, revealed the care plan had not been revised to include the UTI diagnosed April 26, 2014. Interview with Licensed Practical Nurse #12 on May 6, 2014, in the East Hall Dining Room confirmed the care plan had not been revised to include the UTI.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to provide necessary equipment in a timely manner for one resident (#63); failed to provide medications in a timely manner for two residents (#63, #113); and failed to correctly document medication administration for one resident (#166) of thirty-five residents reviewed. The findings included: Resident #63 was admitted to the facility on March 26, 2014, with diagnoses including Chronic Pancreatitis, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hypertension, Neurogenic Bladder, Esophageal Stricture, Osteoarthritis, Atrial Fibrillation, Hiatal Hernia, Unspecified Peptic Ulcer, and History of Pulmonary Emboli.	F 281	F 281 1. Resident #63 is no longer in the Facility. Resident #113 received her medication, PA was informed on 4/29/14 of the delay in the administration of the medication. No adverse consequences were noted. Resident #166 received his medication without any adverse issues, MD was informed on 3/7/14 of the missed documentation of this resident. 2. Current Medication Administration Records will be reviewed by 6/3/14 by the DON / ADONs for complete documentation with MD notification of any discrepancy. 3. ADONs will review medication administration records daily Monday through Friday to identify that medications are being given as ordered and documentation is complete. Audits will continue daily, Monday through Friday, for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Licensed nurses will be educated on emergency pharmacy services being available on a 24 hour basis. Education will also include use of in house Emergency Kits. 4. Findings of the above stated audits will be discussed in the QAPI meetings monthly for 3 months for recommendations and follow up as indicated.	6/17/14

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F 281	Continued From page 5 Medical record review of the Admission Minimum Data Set (MDS) dated April 2, 2014, revealed the resident scored 12 out of 15 on the Brief Interview for Mental Status indicating the resident's cognition was moderately impaired. Continued review revealed the resident required extensive assistance from one person for bed mobility, transfers, walking in the room and hallway, dressing, eating, toilet use, personal hygiene, and bathing. Review of the General Surgery Discharge Summary dated March 25, 2014, revealed, the resident's principal diagnosis at the time of discharge was Chronic Pancreatitis. Continued review revealed the resident had been discharged to the long term care facility with a feeding tube for nutritional support, an indwelling urinary catheter (with a diagnosis of neurogenic bladder and history of performing self-catheterization), and a Jackson-Pratt (JP) drain (A special tube that prevents fluid from collecting near the surgical site by pulling the fluid into a vacuum-producing suction bulb) on the right side of the abdomen. Review of the Nursing Admission Skin Evaluation, Full Body Skin Assessment, dated March 26, 2014, revealed, the resident had a "drain tube" located in the right lower quadrant of the abdomen. Review of the Daily Skilled Nurse's Note dated April 7, 2014, revealed, "...Res (resident) c/o (complained of) abdominal pain @ (at) PEG tube (percutaneous gastrostomy) site et (and) drain. Stomach harder on PEG tube side than drain side. Stomach is not distended at this time...N/O (new order) to ship resident to ER (emergency	F 281		6/17/14

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F 281	Continued From page 6 room)..." Review of the hospital's Emergency Care report dated April 7, 2014, revealed, "Nursing Assessment...Rigid abdomen...G-tube in place...Foley catheter in place...Upper abdomen tender to palpation...Physical Exam...Drain in right side that is not hooked up..." Interview with Licensed Practical Nurse (LPN) #1 on May 7, 2014, at 10:20 a.m., in the conference room, confirmed LPN #1 had completed the resident's Nursing Admission Information and the Nursing Admission Skin Evaluation on March 26, 2014. Continued interview confirmed the resident's JP drain was not intact at the time of admission, and confirmed the vacuum suction bulb (collection reservoir) was missing from the end of the drainage tube. Continued interview confirmed LPN #1 had attempted to obtain a replacement reservoir through the facility's central supply office, but could not recall when this action occurred. Continued interview with LPN #1 confirmed, no recollection of the date the replacement JP vacuum reservoir had been obtained and connected to the resident's JP drain tube. Review of the laboratory tests performed during the resident's emergency room visit revealed a clean catch urine specimen with culture was performed on April 7, 2014, at 10:25 p.m. Review of the physician's communication log entry, undated, and written between April 11, and April 15, 2014, by Licensed Practical Nurse #7, revealed the resident had requested to use antibiotics prescribed from the previous visit to the emergency room on April 7, 2014. Continued	F 281		6/17/14

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F 281	Continued From page 7 review revealed the physician responded on April 14, 2014, with a question,"For what?" Continued review revealed LPN #7 responded with the following in writing, "...(resident) says...(named hospital) Dx (diagnosis) UTI (urinary tract infection)..." Continued review revealed no further communication regarding the antibiotics noted in the physician's communication log. Review of the Emergency Care record dated April 7, 2014, revealed, no documentation for the diagnosis of Urinary Tract Infection. Review of the Physician's Orders dated April 8, 2014, following the resident's emergency room admission revealed no orders for antibiotics. Interview with the Unit Manager/LPN #13 on May 12, 2014, at the Skilled Nurses Station, confirmed no knowledge of the entry in the physician's communication log, and confirmed no follow-up had been done by the facility. Resident #113 was admitted to the facility on November 11, 2009, with diagnoses including Simple Schizophrenia, Chronic Obstructive Pulmonary Disease, Dysphagia, Hypertension, Diabetes and Epilepsy. Review of the Quarterly Minimum Data Set (MDS), dated February 6, 2014, revealed the resident scored a 3 on the Brief Interview for Mental Status, indicating the resident was cognitively impaired. Medical Record Review of the Physician's Recapitulation Orders dated April 1, 2014, through April 30, 2014, revealed, "...Mirtazapine	F 281		6/17/14

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F 281	Continued From page 8 15 milligrams (mg) By Mouth (po) at Bedtime..."(Mirtazapine is the generic name for Remeron, an antidepressant medication.) Medical Record Review of the Medication Administration Record (MAR) dated April 2014, revealed, "...April 24th was initialed with a circle around initials..." Further review on the backside of the MAR revealed, "...Remeron not given awaiting pharmacy arrival..." Review of the facility policy, Emergency Pharmacy Service and Emergency Kits (E-KITS), revealed, "...Emergency pharmaceutical service is available on a 24-hour basis. Emergency needs for medication are met by using the nursing care center's approved emergency medication supply or by special order from the provider pharmacy..." Interview on May 8, 2014, at 2:30 p.m., with the Care Consultant and the Administrator in the Administrator's office, confirmed the facility failed to use the Emergency Kit to obtain the routine medication for resident #113. Interview on May 12, 2014, at 11:00 a.m., with Licensed Practical Nurse #3 in the Human Resource Office, confirmed "...I did not think to get it out of the Emergency Kit..."	F 281		6/17/14
F 312 SS=D	C/O #33782 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312	1. Resident #34 nails were trimmed and filed on 5/7/2014 per licensed staff due to diagnosis of DM.	

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F 312	Continued From page 9 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide nail care for one resident (#34) of thirty-five residents reviewed. The findings included: Resident #34 was admitted to the facility on August 19, 2013, with diagnoses including Diabetes, Hypertension, Hyperlipidemia, and History of Bilateral Subdural Hematomas. Medical record review of the Quarterly Minimum Data Set dated February 17, 2014, revealed the resident scored a four on the Brief Interview for Mental Status (BIMS) indicating the resident had severly impaired cognitive skills, and required two person assistance for personal hygiene. Medical record review of the Care Plan reviewed on February 19, 2014, revealed "...Resident has ADL (activities of daily living) Self-Care Deficit...bathe/shower/nail care...2x (times) week..." Observations on May 5, 2014, at 2:09 p.m., and May 7, 2014, at 10:00 a.m., revealed the resident lying awake on the bed with long, jagged fingernails. Observation and interview on May 7, 2014, at 10:45 a.m., with Licensed Practical Nurse (LPN)	F 312	2. All residents with ADL assist of 1 person or more will be identified through the MDS process and nail care will be provided as needed by 6/6/14. Dependent residents with a diagnosis of DM, nail care will be provided by licensed nurses by 6/6/14. 3. Shower sheets will be reviewed by Wound care nurse daily Monday through Friday to ensure nail care is provided. 10% of dependent residents will be assessed weekly by ADON/ Wound nurse, to ensure proper nail care has been by completed. Education will be provided to Certified Nursing Assistants and Licensed Nurses by SDC on completing ADL care to include nail care with documentation on shower sheets by 6/17/14 4. Findings of the above stated audits will be discussed in the QAPI meetings monthly for 3 months for recommendations and follow up as indicated.	6/17/14

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F 312	Continued From page 10 #3, revealed the resident lying on the bed and confirmed the fingernails were long, jagged,thick and needed to be trimmed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place to protect the skin for one resident (#99) of thirty-five residents reviewed. The findings included: Resident #99 was admitted to the facility on February 23, 2009, with diagnoses including Left Hip Fracture, Dementia, Renal Disease, and Hypertension. Medical record review of a physician's order dated April 27, 2014, revealed, "Clean areas to (L) (left) upper arm, (L) forearm and (L) hand with soap and water, apply TAO (triple antibiotic ointment) and cover with steri strips..." Medical record review of a nursing note dated April 27, 2014, at 4:00 p.m., revealed "...CNA (Certified Nursing Assistant) was walking down	F 323	F 323 1. Resident #99 has a care plan to support the use of geri sleeves or long sleeve shirts as the resident allows. Resident #99's geri sleeves were reapplied. 2. An audit will be completed on all residents with geri sleeves and care plans will be reviewed and updated as needed by 6/17/14. 3. Education will be provided to licensed nurses and certified nursing assistants related to proper placement of geri sleeves by SDC by 6/17/14. Residents who wear geri sleeves will be audited daily by licensed staff for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Care plans will be compared to MD orders by DON / ADONs / MDS nurse and will be updated as needed by 6/17/14. 4. Findings of the above stated audits will be discussed in the QAPI meeting monthly for 3 months for recommendations and follow up as indicated.	6/17/14

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PRINTED: 05/15/2014
FORM APPROVED
OMB NO. 0938-0391

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	445143	A. BUILDING _____ B. WING _____	05/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT ROCKWOOD, THE	5690 ROANE STATE HWY ROCKWOOD, TN 37854

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F 323	Continued From page 11 hallway and seen this res (resident) in another res room and noticed skin tears...Large skin tear noted to left upper arm, small skin tear noted to left lower arm...appears res ran into a doorway and scraped arm...fragile skin/confused...dementia/anxiety..." Medical record review of the April 2014, physician's recapitulation orders revealed "...Geri sleeves or long sleeves as resident allows Dx (diagnosis): S/T (skin tear)..." Medical record review of the Care Plan, reviewed on February 28, 2014, revealed "...ADL (activities of daily living)...fragile skin, skin tears & bruises easily...gerisleeves..." Observation on May 5, 2014, at 12:22 p.m., revealed the resident seated in a merrywalker, with short sleeves and visible skin tears with steri strips in place on the left upper and lower arm, above and below the elbow, and no geri sleeves were in place. Interview on May 7, 2014, at 10:40 a.m., with Licensed Practical Nurse (LPN) #13, (nurse who authored the nursing note dated April 27, 2014), at the nursing station, revealed was unsure if the geri sleeves were in place on April 27, 2014. Continued interview confirmed the geri sleeves or long sleeves were to be in place at all times.	F 323		6/17/14
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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BRIDGE AT ROCKWOOD, THE	5585 ROANE STATE HWY ROCKWOOD, TN 37854

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F 333	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to prevent the administration of an anticoagulant after the medication had been discontinued for one resident (#63) of thirty-five residents reviewed. The findings included: Resident #63 was admitted to the facility on March 26, 2014, with diagnoses including Chronic Pancreatitis, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hypertension, Neurogenic Bladder, Esophageal Stricture, Osteoarthritis, Atrial Fibrillation, Hiatal Hernia, Unspecified Peptic Ulcer, and History of Pulmonary Emboli. Review of the Admission Orders dated March 26, 2014, revealed, "...heparin (an anticoagulant medication used in the prevention of blood clots) subq (subcutaneous) inj (injection) 5000U (units) q (every) 8 hr (hours) ..." Review of the physician's communication log dated April 19, 2014, revealed, "Need stop date on Heparin." Review of the Physician's Order dated April 19, 2014, and timed 10:00 p.m., revealed, "...D/C (discontinue) heparin T/O (telephone order) ... (named physician)." Review of the Medication Administration Record (MAR) dated April 2014, revealed the resident's heparin injections were scheduled to be given at 9:00 a.m., 5:00 p.m., and 1:00 a.m. Continued review revealed the resident received six doses	F 333	F 333 1. Resident #63 no longer resides in the Facility. 2. Medication administration records for residents with orders for Heparin were reviewed by the ADONs by 5/21/14. There were no negative findings. Residents who receive Heparin MARs wil be audited daily Monday through Friday to ensure medications are administered as ordered. Any areas of discrepancy will be addressed immediately. 3.Education will be completed for licensed nursing staff by the SDC regarding the importance of the administration of Heparin as ordered by 6/17/14. The ADONs, MDS nurse, or DON will audit medication administration records daily Monday through Friday for 4 weeks, then weekly for 3 months to ensure appropriate administration of Heparin as ordered. 4. Findings of the above stated audit will include Heparin administration and will be discussed in the QAPI meeting monthly for 3 months for recommendations and further follow up as indicated.	6/17/14

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F 333	Continued From page 13 of the anticoagulant after the physician's order to discontinue the medication at 10:00 p.m., on April 19, 2014. Interview with the Interim Director of Nursing in the conference room on May 8, 2014, at 1:30 p.m., confirmed the resident continued to receive the heparin injections after the physician's order to discontinue the medication.	F 333		6/17/14
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain a complete and accurate medical record for two residents (#6, #63, #166) of thirty-five residents reviewed. The findings included: Resident #6 was admitted to the facility on March	F 514	F 514 1. Head to toe skin assessment of Resident #6 was completed with PA notified of results on 5/8/14. Resident #63 no longer resides in Facility. Audit of chart and Medication Administration Record for resident #166 was completed along with a pain assessment on 3/6/14 by ADON. MD aware with no new changes. 2. Current residents who have pain medication ordered will have the records audited to ensure pain medication is documented on the narcotic sheets, MAR, and pain flow sheet as warranted. Current residents will have skin assessments completed to identify any skin changes by 5/11/14 by ADONs, wound care nurse,and the medical records nurse. Skilled residents that admitted to Facility since 5/15/14 will have an audit of chart for documentation and assessments by DON / ADONs with any issues addressed as needed. Baseline vital signs will be obtained on current residents by CNA's / licensed nurses by 6/6/14. 3. Licensed staff will be educated on SBAR process, proper skin assessments, documentation related to medication administration, and all documentation requirements by SDC / ADONs by 6/17/14. DON, ADON, MDS nurse, Wound care nurse will	

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F 614	Continued From page 14 21, 2008, with diagnoses including Chronic Airway Obstruction, Hypothyroidism and Psychosis. Medical record review of the Weekly Skin Integrity Review dated May 7, 2014, revealed no documentation the resident had a bruise. Observation on May 8, 2014, at 10:30 a.m., with Licensed Practical Nurse (LPN) #9, revealed the resident seated in a wheelchair, outside the beauty shop area. Continued observation revealed the resident had a bruised area above the left lateral wrist. Interview on May 8, 2014, at 10:35 a.m., with Licensed Practical Nurse #9 at the nursing station, revealed the bruise appeared to be fading, did not know how the bruise occurred, and confirmed the Weekly Skin Integrity Review dated May 7, 2014, was not accurate, and did not address the resident's bruise on the left lateral wrist. Resident #63 was admitted to the facility on March 26, 2014, with diagnoses including Chronic Pancreatitis, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hypertension, Neurogenic Bladder, Esophageal Stricture, Osteoarthritis, Atrial Fibrillation, Hiatal Hernia, Unspecified Peptic Ulcer, and History of Pulmonary Emboli. Review of the PRN (as needed) Administration Record for April 2014, revealed the resident received Oxycodone 15 milligrams (mg) by mouth every three hours as needed for pain on April 22, 2014, at 2:00 a.m., and 5:00 a.m. Review of the	F 514	review documentation of skilled residents or any resident with a change of condition for completeness daily Monday through Friday for 2 weeks, weekly for 4 weeks and monthly for 3 weeks. 4. Findings of the above stated audits will be discussed in the QAPI meetings monthly for 3 months for recommendations and follow up as indicated.	6/17/14

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F 514	Continued From page 15 Nurse's Medication Notes dated April 22, 2014, at 6:00 a.m., revealed, Oxycodone 15 mg, had been administered to resident #63 for complaints of ABD (abdominal pain) with reported effectiveness at 7:00 a.m., of no (circle with line through it indicating "no") C/O (complaints of). Medical record review of the Nurse's Notes dated April 22, 2014, at 6:30 a.m., revealed, emergency medical services (EMS) arrived at the facility to transport the resident to the emergency room with assisted ventilation in progress. Interview with Licensed Practical Nurse (LPN) #1 in the conference room on May 7, 2014, at 7:40 a.m., confirmed the LPN had documented the effectiveness of the pain medication prior to conducting the actual assessment resulting in an inaccurate medical record. Review of the General Surgery Discharge Summary dated March 25, 2014, revealed, the resident's principal diagnosis at the time of discharge was Chronic Pancreatitis. Continued review revealed the resident had been discharged to the long term care facility with a feeding tube for nutritional support, an indwelling urinary catheter (for a diagnosis of neurogenic bladder with history of performing self-catheterization), and a right Jackson-Pratt (JP) drain (A special tube that prevents body fluid from collecting near the surgical site by pulling the fluid into a vacuum-producing suction bulb). Review of the Nurse's Notes and the Daily Skilled Nurse's Notes dated March 26, through April 21, 2014, revealed, four of the twenty-seven days/opportunities for charting resident assessments were blank. Continued review of	F 514		

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F 514	Continued From page 16 the Nurse's Notes revealed sixteen of the twenty-seven days had no vital signs (blood pressure, heart rate, respirations, temperature) recorded. Interview with the Unit Manager/Licensed Practical Nurse #13, on May 12, 2014, at 9:00 a.m., confirmed, vital signs should be taken every shift, and the resident should have been assessed daily. Continued interview confirmed the medical record was incomplete. Resident #166 was admitted to the facility on August 15, 2013, with diagnoses including Dementia with Behavioral Disturbances, Depressive Disorder, Anxiety State, Idiopathic Peripheral Neuropathy, and Parkinson's Disease. Medical record review of the Quarterly Minimum Data Set (MDS) dated March 3, 2014, revealed, Section J: Pain Management: The resident received scheduled and as needed (PRN) pain medication as well as non-medication intervention. Continued review revealed the resident had pain over the last 5 days, with pain occurring occasionally, with the worst pain level being a "3" on a 1-10 scale. Medical record review of the resident's Care Plan dated December 12, 2013, and updated March 11, 2014, revealed the resident had been care planned for "... pain, chronic, complains of pain..." Continued review of the care plan revealed, Approaches to include administeration and monitoring for effectiveness and possible side effects from the routine pain medicine and PRN pain medicine. Medical record review of the Physician's Order	F 514		

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F 514	Continued From page 17 dated March 21, 2013, revealed an order for Hydrocodone (Narcotic pain medication) 5/325 (mg) milligrams every six hours PRN (as needed). Facility Policy review of the "Medication Administration-Administering Medications Policy dated December 2012, revealed "...7. Record the medication given on the medication record..." Medical record review of the facility's Controlled Drug Record for resident #166 revealed, the Hydrocodone 5/325 mg was signed out as administered to the resident on April 9 (3 doses), April 15 (2 doses), April 19 (2 doses), April 20 (2 doses), April 21(2 doses), April 22(2 doses), April 23(2 doses), April 25, April 30(2 doses), May 1, May 3(2 doses), and May 7, 2014. Review of the resident's Medication Administration Record (MAR) for April 2014 and May 2014, did not reflect the medication being administered for those dates. Interview with the Interim Director of Nursing on May 8, 2014, at 2:45 p.m., in the conference room confirmed the medication administration had not been documented on the MAR and confirmed the facility failed to ensure the medical record (MAR) was accurate or complete.	F 514		